Kelly Wright
certified rolfer

Client Health Information

NAME

TODAY'S DATE

How were you referred to Rolfing?

Have you been Rolfed before? no ❑ yes ❑ If yes, when? Please describe your experience :

Previous bodywork experience? ❑ Acupuncture ❑ Craniosacral ❑ Chiropractic ❑ Massage ❑ Physical Therapy ❑ other

Please explain:

Are you under the care of a physician? no ❑ yes ❑ If yes, please explain:

Are you taking medication prescribed by a physician? no ❑ yes ❑ If yes, please explain:

Women: Are you pregnant? no ❑ yes ❑ If yes, what trimester?

ANY HISTORY OF (please check those that apply):

❑ Car accident	❑ Heart Condition	❑ Cancer	❑ Low blood pressure	❑ High blood pressure
❑ Diabetes	❑ Respiratory Disorder	❑ Asthma	❑ Digestive Disorder	❑ Epilepsy
❑ Osteoporosis	❑ Headaches	❑ Migraines	❑ Arthritis	❑ Head injures
❑ Broken Bones	❑ Sprains	❑ Mental / Nervous disorder		

Please elaborate on any checked items:

Do you have any chronic complaints? If yes, please explain:

What, if anything, have you found to help with your current situation?

What would you like to experience from Rolfing? What are your Rolfing goals?

Additional information and / or comments:

Kelly Wright ~ 970.759.6115
WWW.KELLYRWRIGHT.COM ~ ROLFING@KELLYRWRIGHT.COM